



**Texas Department of Insurance, Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

**MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

**PART I: GENERAL INFORMATION**

Requestor's Name and Address:  SURGERY SPECIALTY HOSPITALS OF AMERICA S.E HOUSTON CAMPUS 4301 VISTA ROAD PASADENA, TX 77504	MFDR Tracking #: M4-09-B316-01
Respondent Name and Box #:  CITY OF HOUSTON REP BOX:: 42	

**PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Requestor's Position Summary "The Carrier applied the incorrect reimbursement methodology to Providers charges."

Principle Documentation:

1. DWC 60 package
2. UB04
3. EOB(s)
4. Medical Reports
5. Total Amount Sought \$1,584.47

**PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION**

Respondent's Position Summary: N/A; not required due to file not being eligible for review by Medical Fee Dispute Resolution.

**PART IV: SUMMARY OF FINDINGS**

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
08/08/08	16, 272, 785 ,97, INR	Outpatient Services	\$1,584.47	\$0.00
Total Due:				\$0.00

**PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION**

1. These services were denied by the Respondent with reason codes
  - a. 16 – Claim/service lacks information which is needed for adjudication.
  - b. 272 – By report code. Please re-submit documentation to support billed charges.
  - c. 785 – Items and/or services are packaged into APC rate. Therefore there is separate APC payment.
  - d. 97 – Payment is included in the allowance for another service/procedure.
  - e. INR – This bill was reviewed through the IMO nurse prescreen process.
2. Medical Fee Dispute Resolution received the Requestors request on 8/10/09. Per Rule 133.307 ( c ) (1) (A-B), the disputed date of service 8/08/08 is outside the one (1) year deadline and therefore not eligible for review.

3. The Division concludes that this dispute was not filed in the form and manner prescribed under Rule 133.307 ( c) (1) (A). As a result, the amount ordered is \$0.00.

**PART VI: GENERAL PAYMENT POLICIES/REFERENCES**

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311  
Rule 133.307

**PART VII: DIVISION DECISION**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to \$0.00 reimbursement.

08/25/09

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
Date

**PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL**

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**